NEW YORK STATE OF OPPORTUNITY. Department of Health

Workforce Workgroup

Gallery walk posters

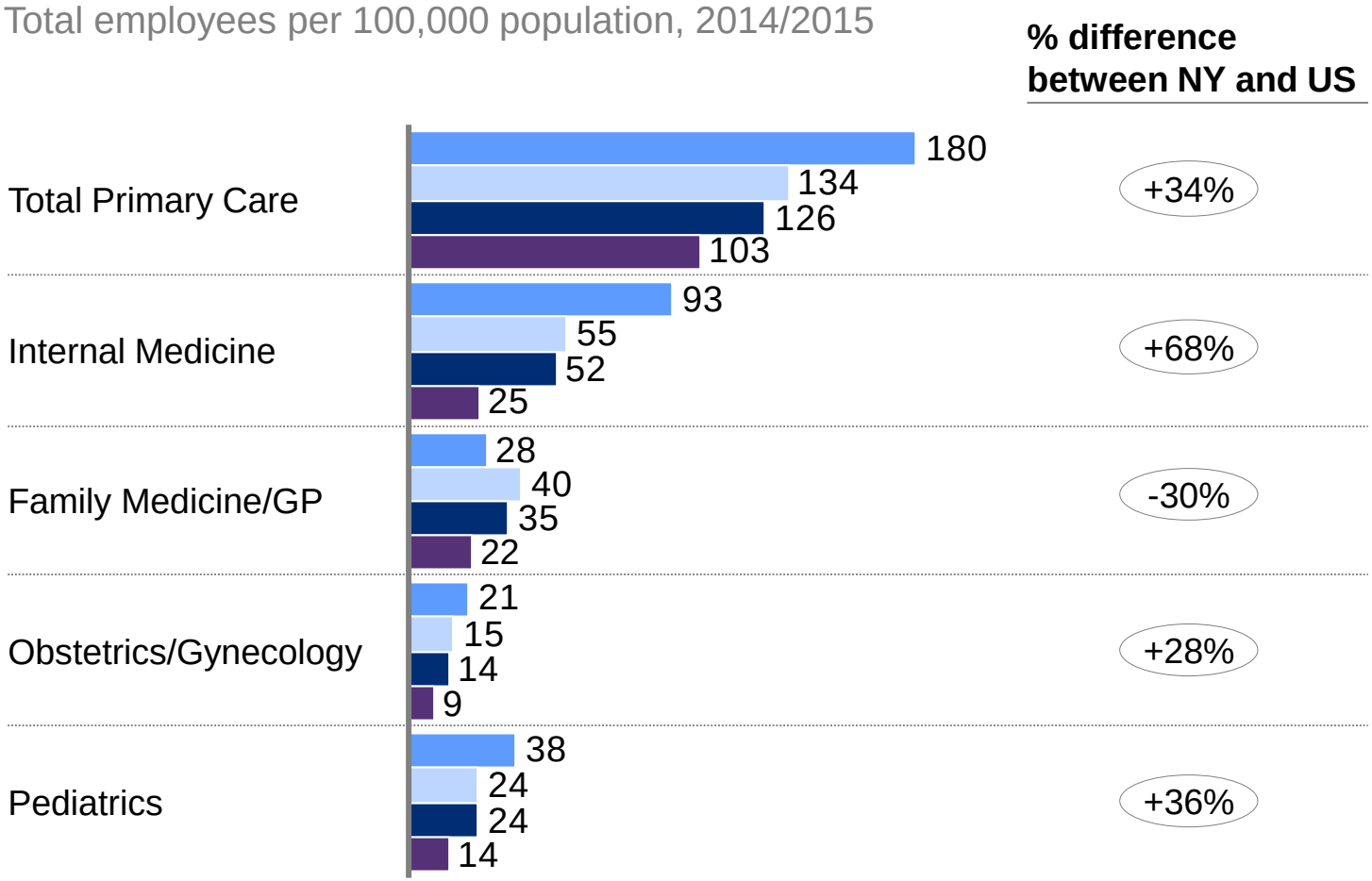
September 2, 2015

Primary care physician supply per 100,000 population

NY CA US TX

Primary care physicians

Total employees per 100,000 population, 2014/2015



Comments

Questions

Source: Kaiser State Health Facts: State Licensing Information from Redi-Data, Inc, March 2015; U.S. Census Bureau, 2014

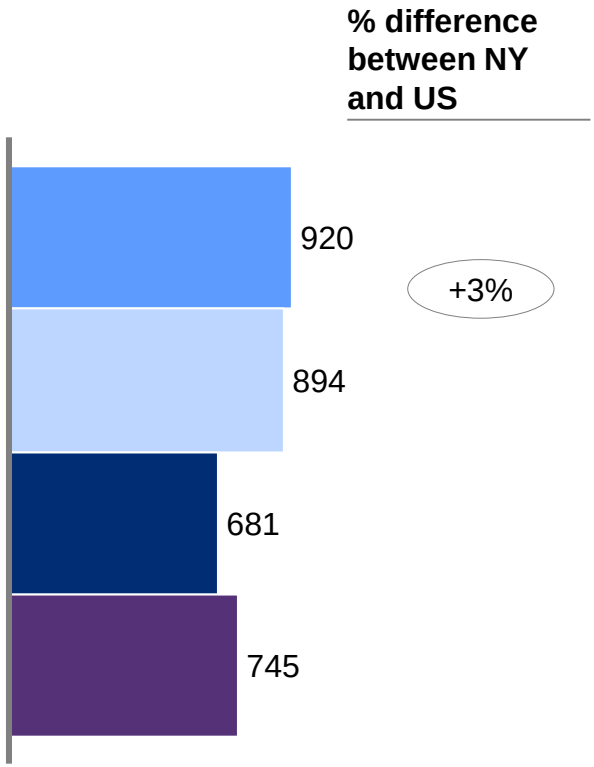
NEW YORK STATE OF OPPORTUNITY. Department of Health

Nurse supply per 100,000 population

NY CA US TX

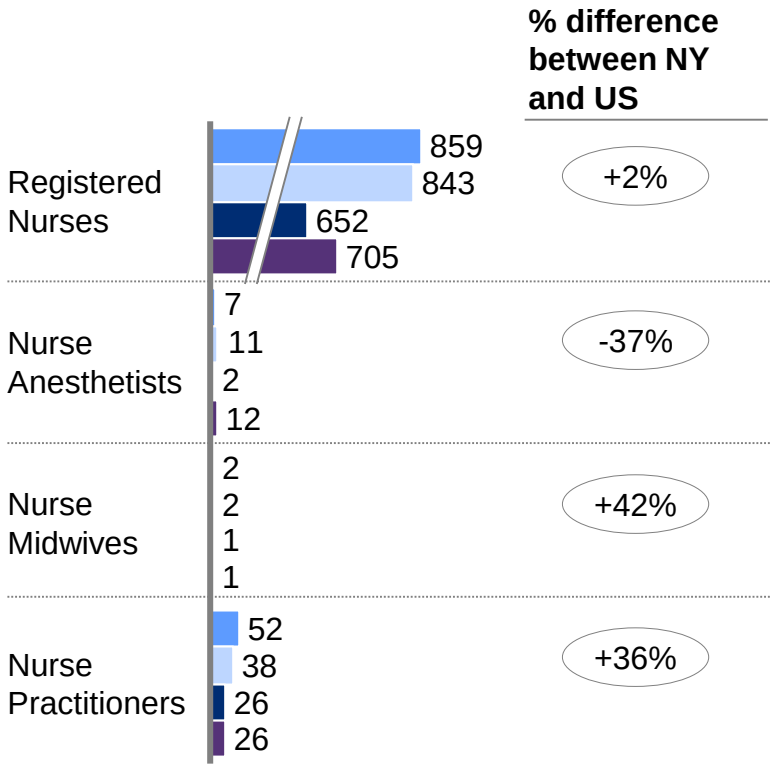
Total nurses[1]

Total employees per 100,000 population, 2014



Nurses by sub-type

Total employees per 100,000 population, 2014



Comments

Questions

1 Does not include LPN/LVNs

Source: U.S. Department of Labor Statistics May 2014, U.S. Census Bureau 2014

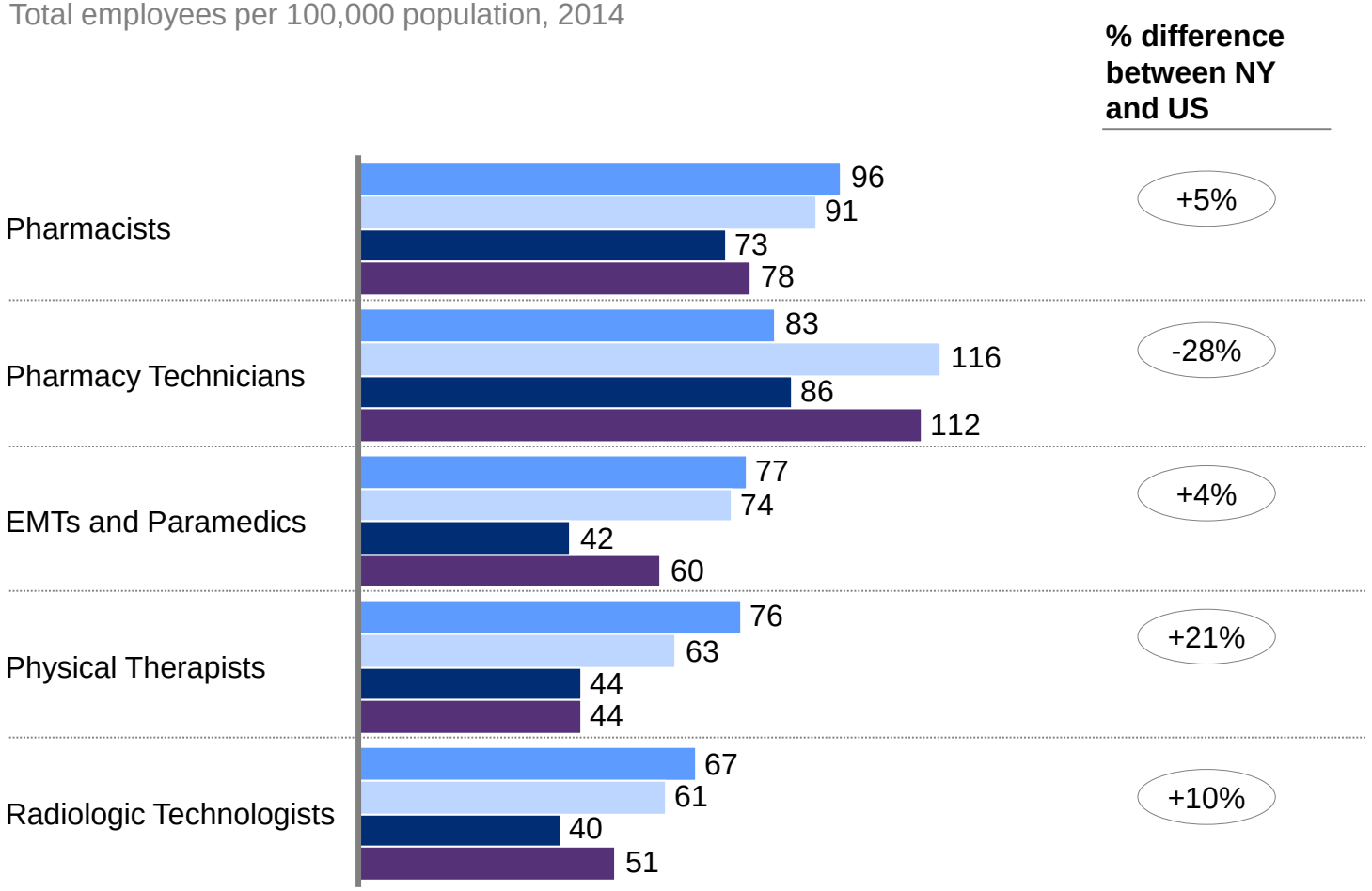
NEW YORK STATE OF OPPORTUNITY. Department of Health

Allied health professional supply per 100,000 population (1/2)

NY CA US TX

Selected allied health professionals[1]

Total employees per 100,000 population, 2014



Comments

Questions

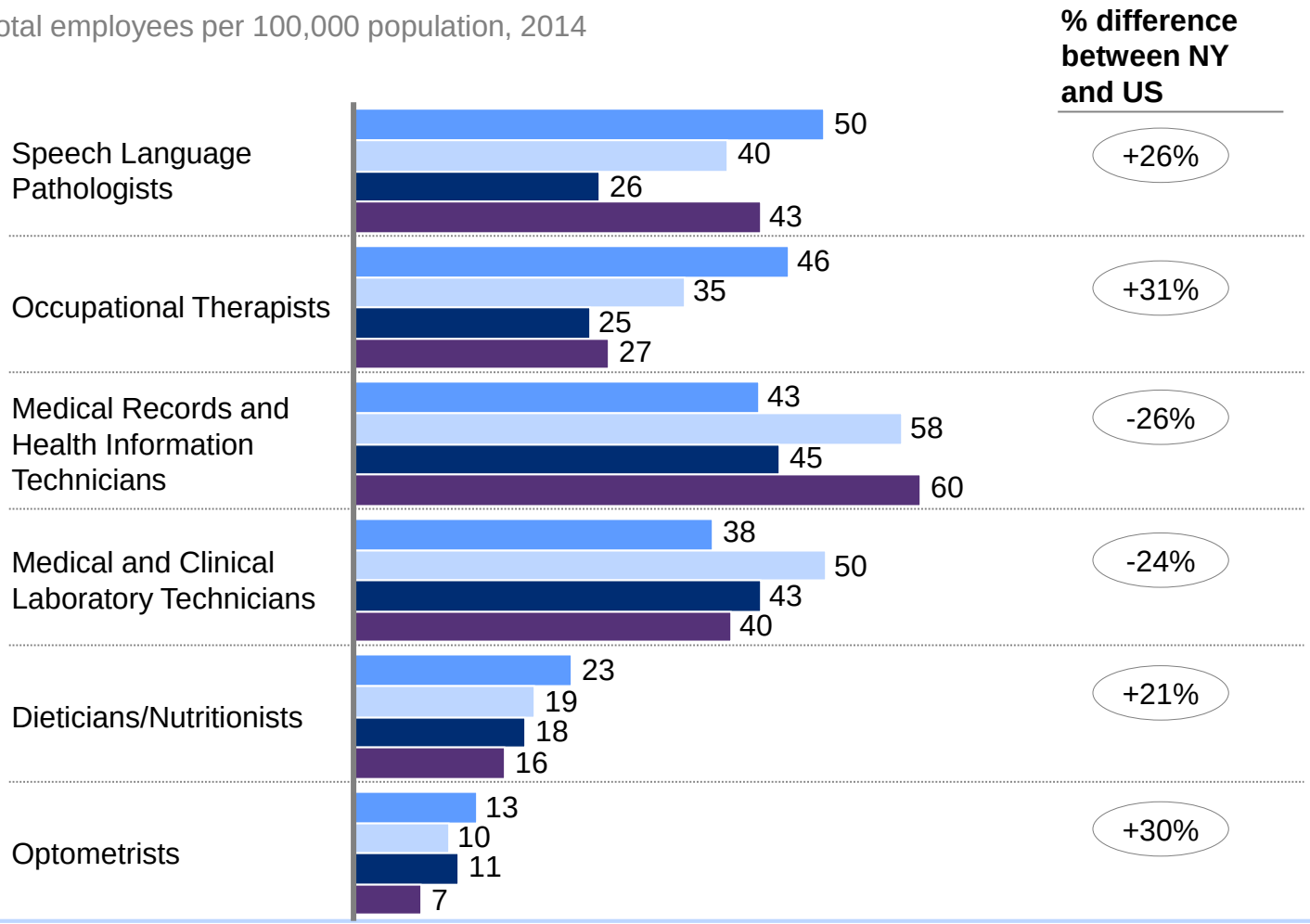
1 Allied health professions on this page are those with 5 largest employment figures in New York
Source: U.S. Department of Labor Statistics May 2014, U.S. Census Bureau 2014

Allied health professional supply per 100,000 population (2/2)

NY CA US TX

Selected allied health professionals[1]

Total employees per 100,000 population, 2014



Comments

Questions

1 Allied health professions on this page are those with four next highest largest employment figures, plus dieticians and optometrists

Source: U.S. Department of Labor Statistics May 2014, U.S. Census Bureau 2014

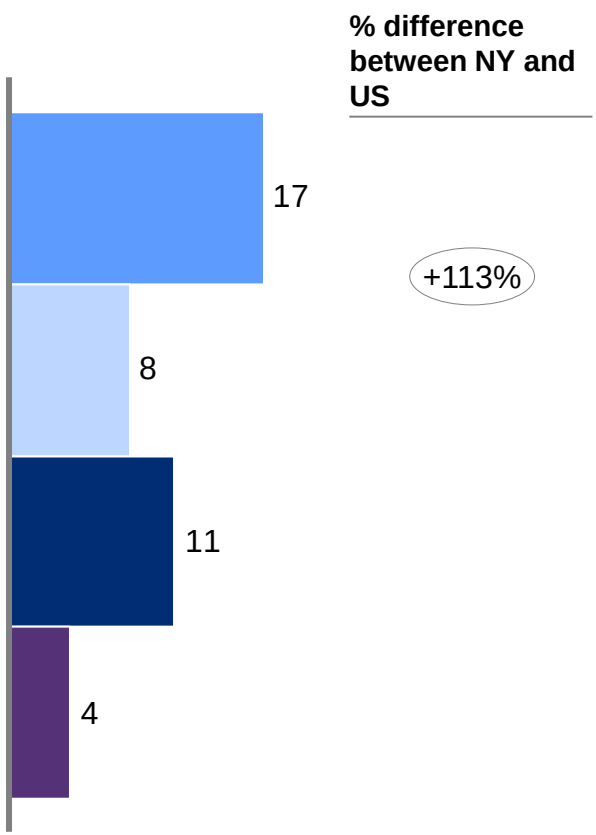
NEW YORK STATE OF OPPORTUNITY. Department of Health

Behavioral health professional supply per 100,000 population

NY CA US TX

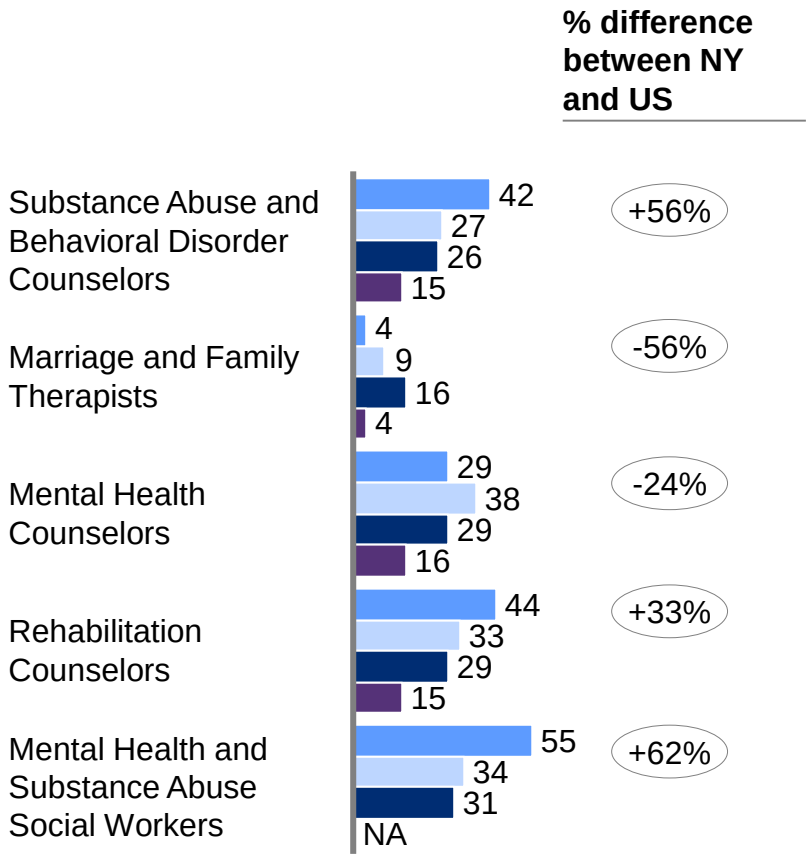
Psychiatrists

Total employees per 100,000 population, 2014



Other Behavioral Health Professionals

Total employees per 100,000 population, 2014



Comments

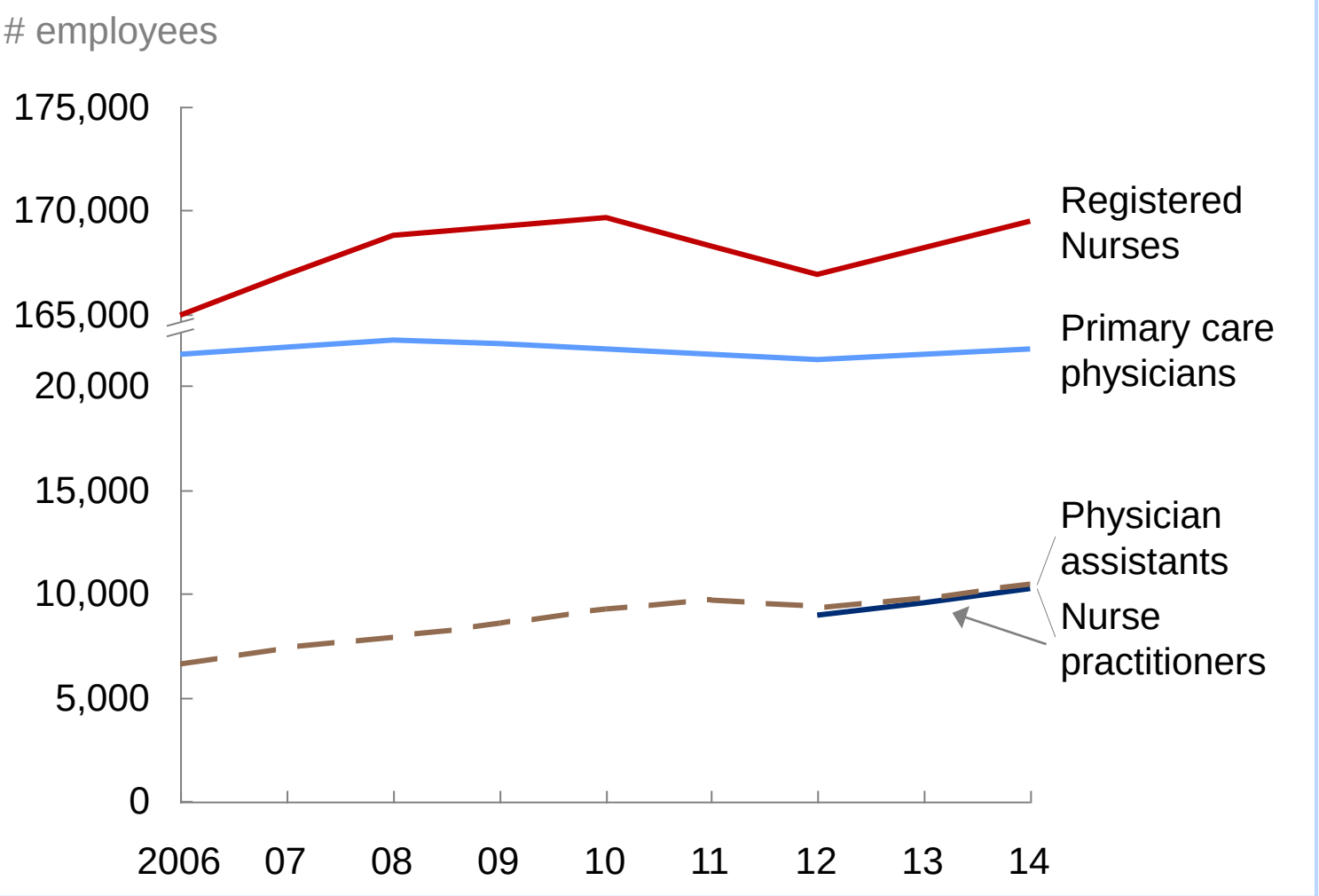
Questions

Source: U.S. Department of Labor Statistics May 2014, U.S. Census Bureau 2014

NEW YORK STATE OF OPPORTUNITY. Department of Health

Health care workforce employment trends

Health care workforce employment in New York, 2006-2014



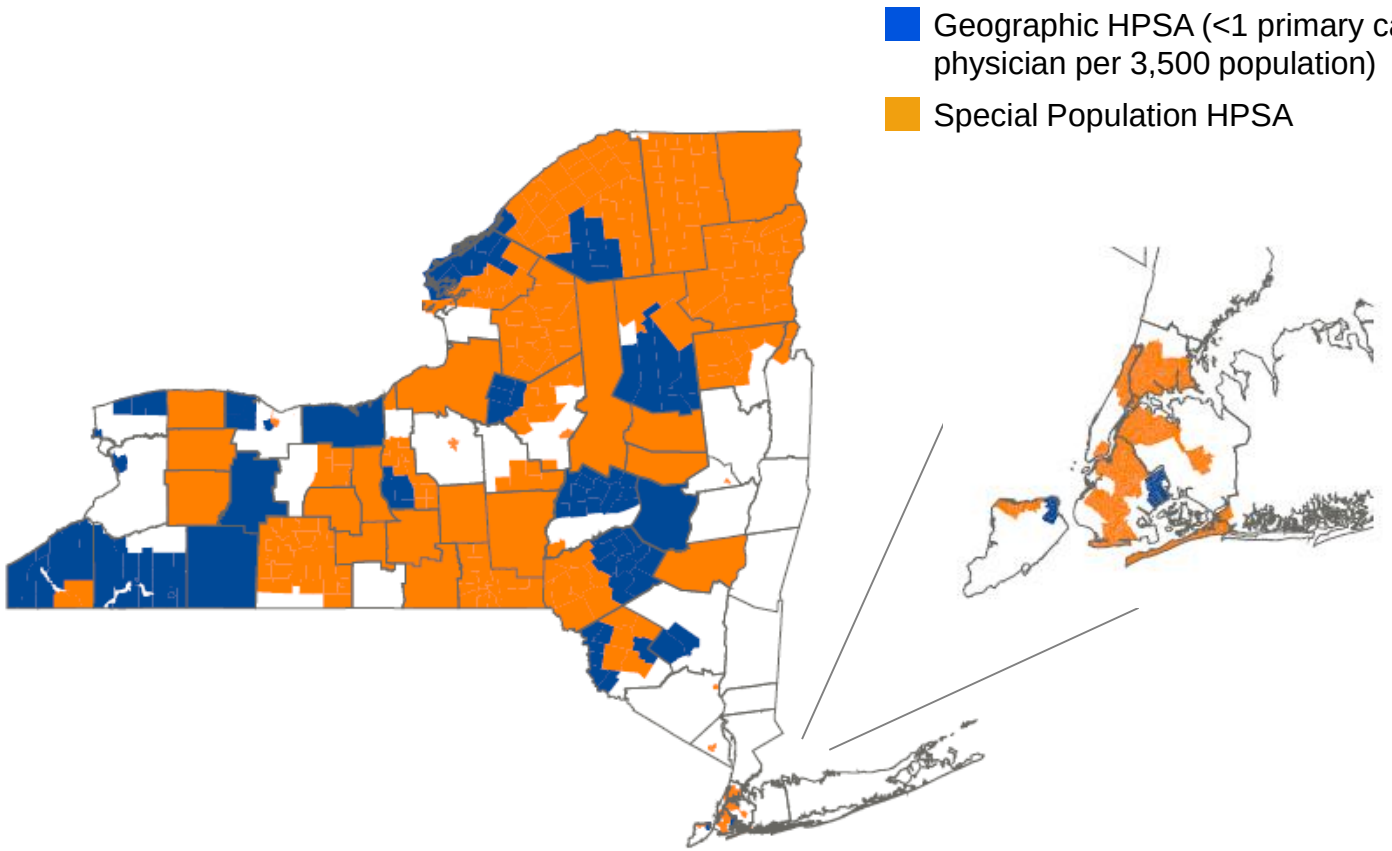
Comments

Questions

1 Nurse practitioner data only available from 2012-2014
Source: American Association of Medical Colleges MediFile data; U.S. Bureau of Labor Statistics

Distribution of Primary Care Health Professional Shortage Areas (HPSAs)

Primary Care HPSAs



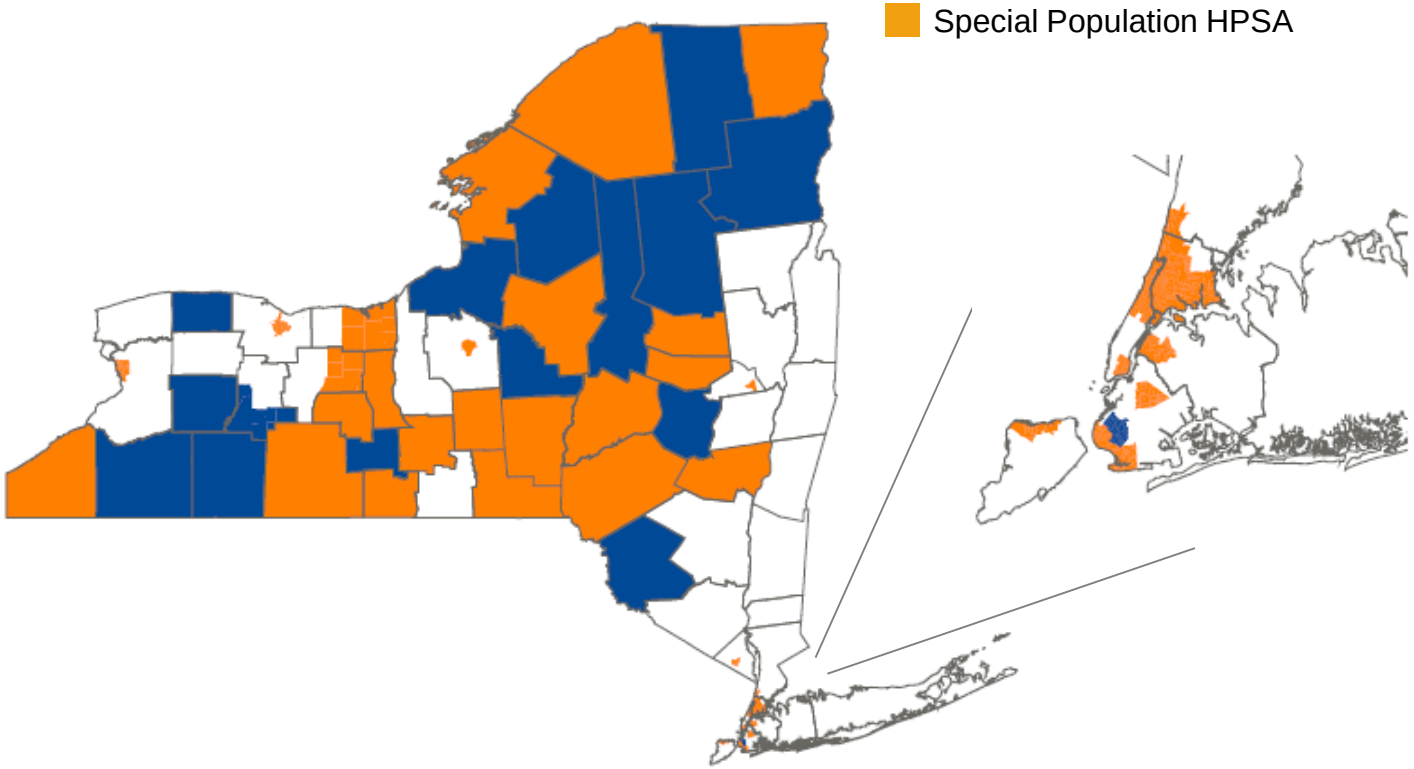
Comments

Questions

Source: HRSA Data Warehouse, 2015; Map developed by Center for Health Workforce Studies

Distribution of Mental Health HPSAs

Mental Health HPSAs



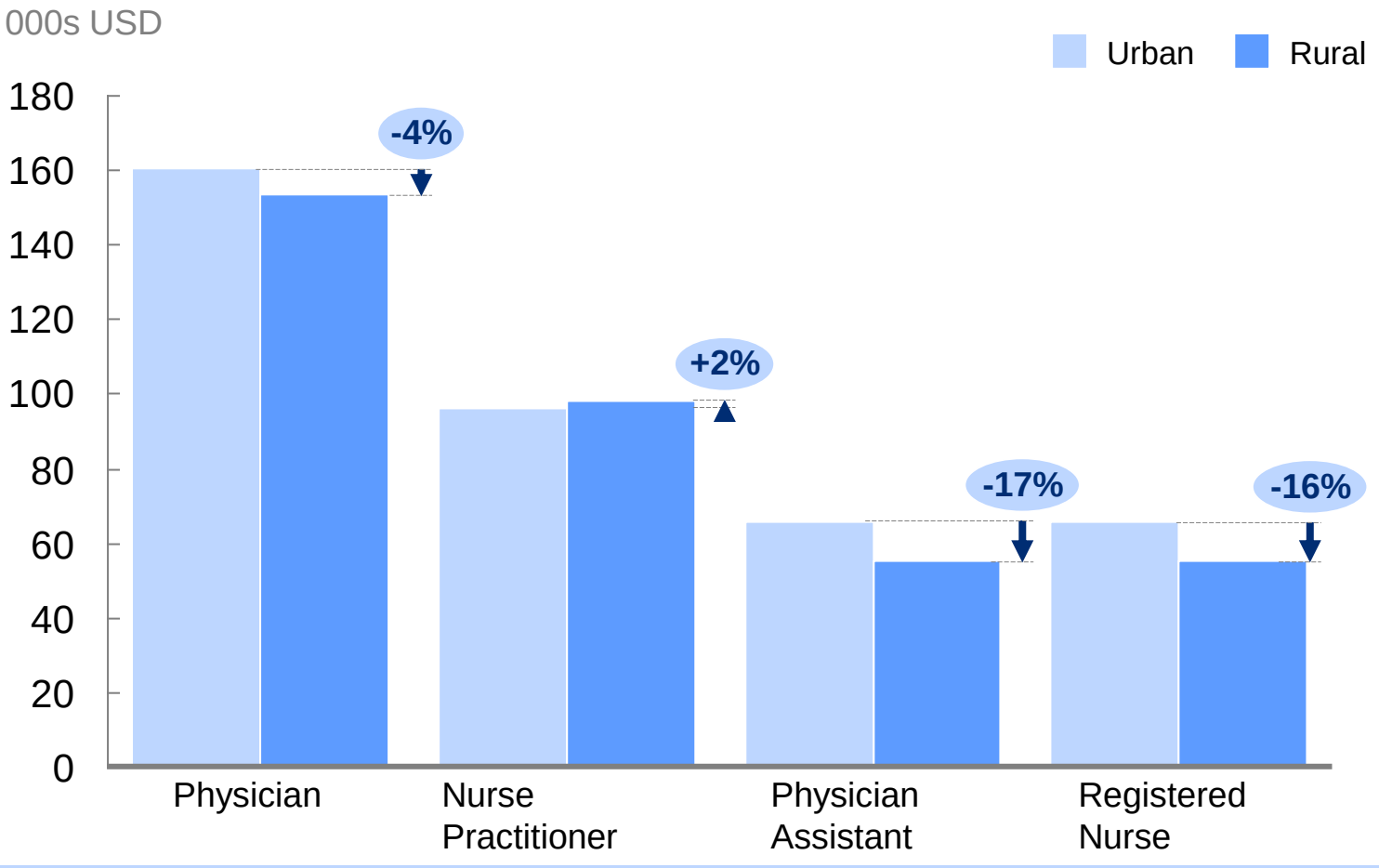
Comments

Questions

Source: HRSA Data Warehouse, 2015; Map developed by Center for Health Workforce Studies

Health care professional incomes, adjusted by cost of living

NY average incomes by provider type, adjusted for (national) cost of living, 2012[1]



Comments

Questions

1 Only 2008 data available for RNs

Source: 2008 National Sample Survey of Registered Nurses, 2012 National Sample Survey of Registered Nurse Practitioners, American Community Survey 2008-2012, salary adjusted to 2012 levels. University of Washington Center for Health Workforce Studies, "Characteristics of Registered Nurses in Rural vs. Urban Areas," 2005.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Literature review on non-financial considerations in health care professionals' choice of urban vs rural setting

NOT EXHAUSTIVE

	Factors in favor of practicing	Factors against practicing
Rural settings	▪ Greater satisfaction in serving small, tight-knit community ▪ Satisfaction in serving needy population ▪ Attraction of living in rural environment (low cost of living, shorter commute, natural beauty)	▪ Lack of rural residency programs; tendency to practice near training location ▪ Lack of professional training opportunities ▪ Longer work hours/concern about "burn out" and work/life balance ▪ Cultural considerations (lack of cultural opportunities, perception that rural areas are less progressive)
Lower income urban settings	▪ Cultural opportunities in urban settings ▪ Satisfaction in serving needy population ▪ Proximity to other professionals ▪ More training opportunities	▪ Hospitals are closing in lower income urban areas ▪ High cost of living in urban settings, potential long commuting times ▪ Longer work hours/concern about "burn out"
Higher-income urban settings	▪ Cultural opportunities in urban settings ▪ Proximity to other professionals ▪ More training opportunities	▪ High cost of living in urban settings

Comments

Questions

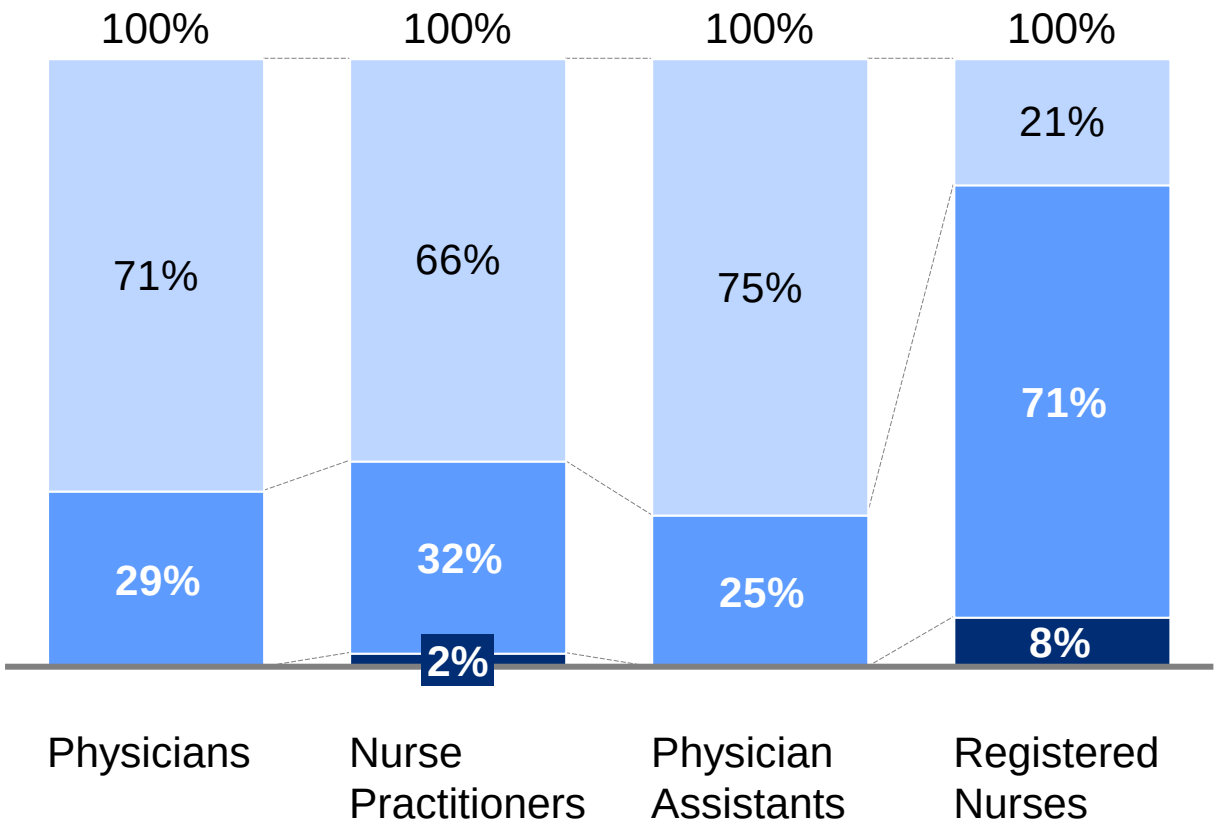
Source: SUNY Buffalo, CHWS "Rural and Urban Physicians in New York," 2012. AAFP.org. The Atlantic "Why Are There So Few Doctors in Rural America?" 2014. CHWS 2014 Residency Exist Survey. Kaiser Health News "Hospitals Lure Doctors Away From Private Practice" 2010. The Atlantic "The Doctor Is Out: Young Talent Is Turning Away From Primary Care," 2012. "Annual Work Hours Across Physician Specialties" 2011. Social Science and Medicine "Medical specialty prestige and lifestyle preferences for medical students" 1982. American Journal of Public Health "Recruiting and Retaining Primary Care Physicians in Urban Underserved Communities: The Importance of Having a Mission to Serve" 2010. Journal Sentinel "Hospitals, doctors moving out of poor city neighborhoods to more affluent areas" 2014.

Practice settings for health care workers (national)

Ambulatory Health Care Services
Hospitals
Nursing and Residential Care Facilities

Practice setting for U.S. health care workers

Percent of providers in each setting



Comments

Questions

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2014

NEW YORK STATE OF OPPORTUNITY. Department of Health

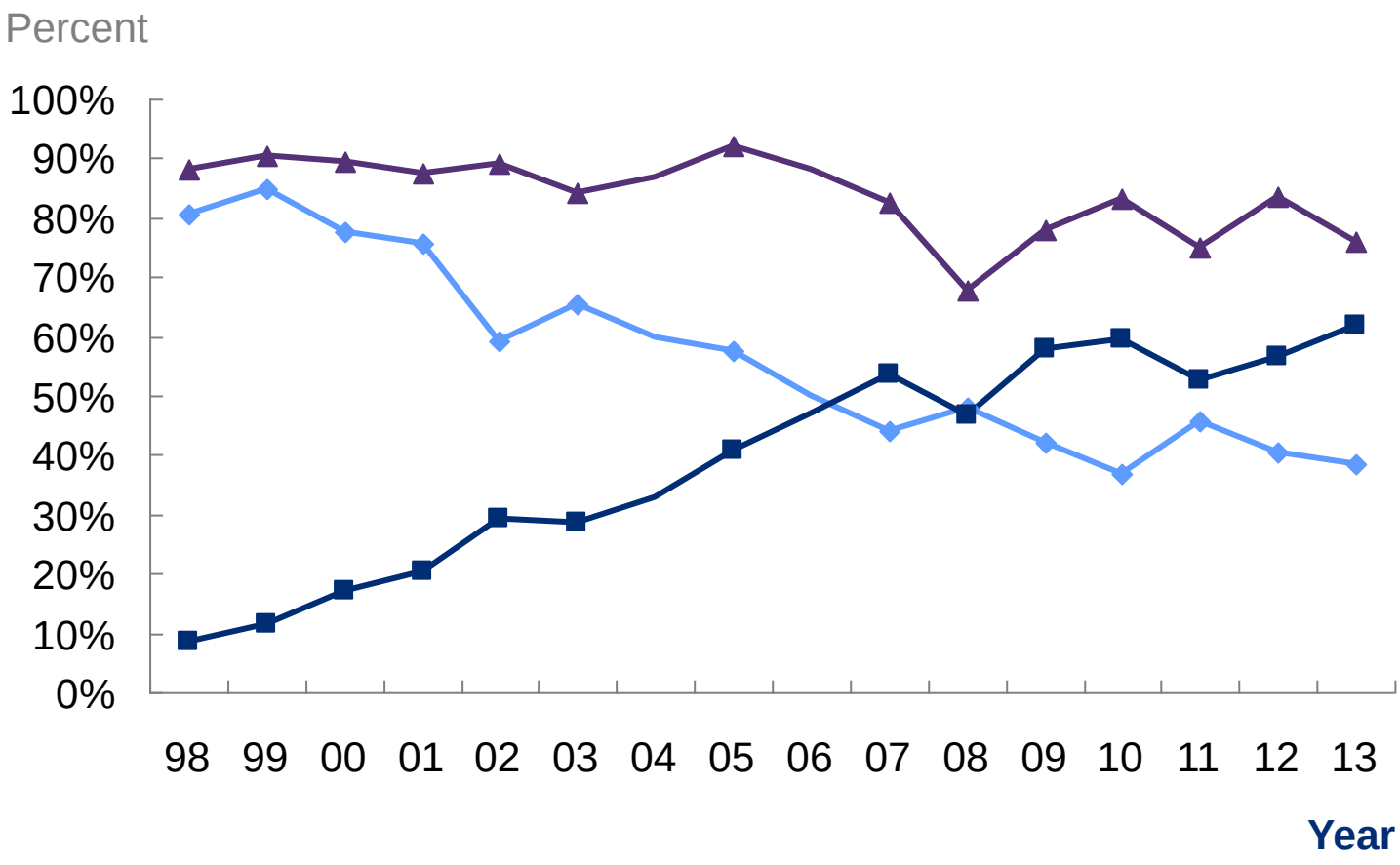
Choice of setting for primary care physicians entering practice in New York State

Percent of general internal medicine physicians entering practice in **community based settings**

Percent of general internal medicine physicians entering practice in **hospital inpatient settings**

Percent of other primary care physicians entering practice in **community based settings**

Physician choice of practice setting



Comments

Questions

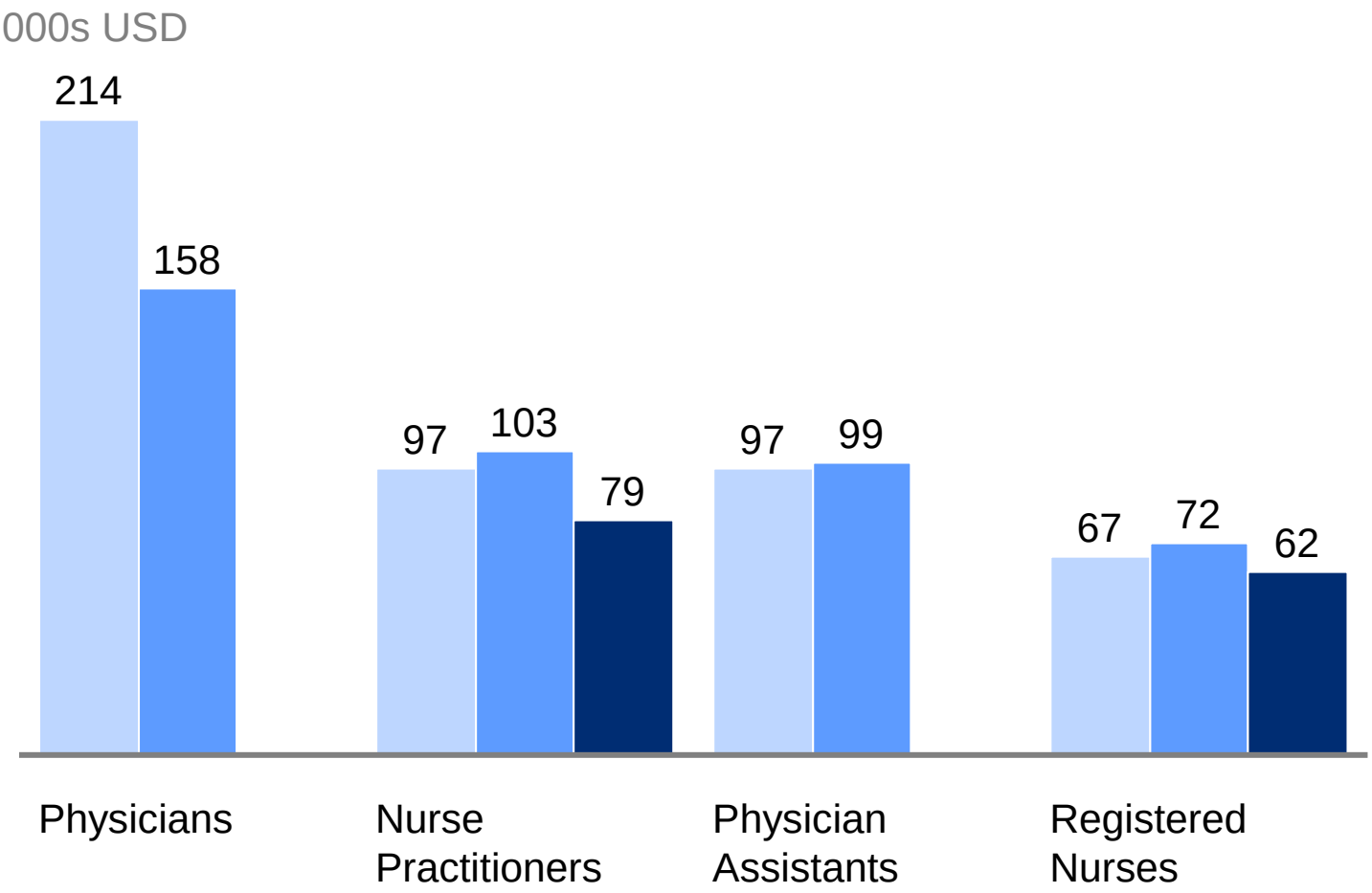
Source: Center for Health Workforce Studies 2013

NEW YORK STATE OF OPPORTUNITY. Department of Health

Income by practice setting

Ambulatory Health Care Services
Hospitals
Nursing and Residential Care Facilities

Annual mean wage by practice setting



Comments

Questions

Note: This is national, not New York State-specific data

Source: U.S. Bureau of Labor Statistics, May 2014

NEW YORK STATE OF OPPORTUNITY. Department of Health

Literature review: non-financial considerations in health care practitioners choice of practice setting (ambulatory vs hospital)

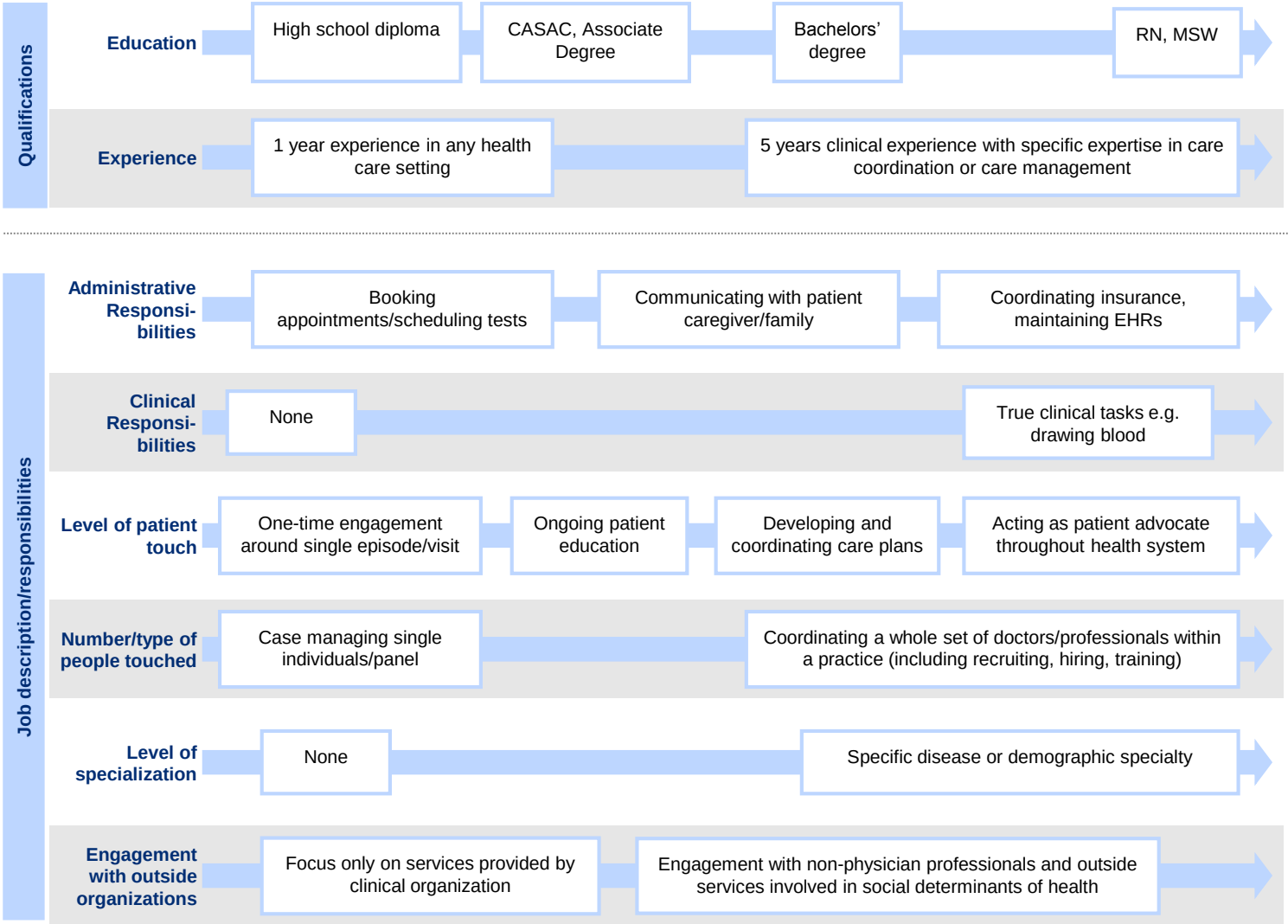
	Factors in favor of practice setting	Factors against practice setting
Ambul-atory/ Out-patient	▪ Ability to develop strong, long-term patient relationships ▪ Sense of ownership over practice ▪ Potential to run own business	▪ Considerable administrative burden of private practice compared to hospital-based practice ▪ Less predictable and manageable hours/lifestyle (on-call status, after-hours responsibilities) ▪ Perceived as less prestigious than hospital-based work/specialties (surgery, internal, intensive care medicine are ranked as most prestigious professions, and all are hospital-based)
Acute/ in-patient	▪ Lower administrative burden ▪ Predictable, manageable hours ▪ Majority of residency programs (~2/3) spent in hospital-based rotations, breeding level of familiarity/comfort ▪ Perceived prestige	▪ Patient population may be sicker overall ▪ Potentially more stressful situations ▪ Employee mentality; more difficult to have sense of ownership over practice

Comments

Questions

Source: SUNY Buffalo, CHWS "Rural and Urban Physicians in New York," 2012. AAFP.org. The Atlantic "Why Are There So Few Doctors in Rural America?" 2014. CHWS 2014 Residency Exist Survey. Kaiser Health News "Hospitals Lure Doctors Away From Private Practice" 2010. The Atlantic "The Doctor Is Out: Young Talent Is Turning Away From Primary Care," 2012. "Annual Work Hours Across Physician Specialties" 2011. Social Science and Medicine "Medical specialty prestige and lifestyle preferences for medical students" 1982. American Journal of Public Health "Recruiting and Retaining Primary Care Physicians in Urban Underserved Communities: The Importance of Having a Mission to Serve" 2010. Journal Sentinel "Hospitals, doctors moving out of poor city neighborhoods to more affluent areas" 2014.

Definitions of care coordinator role across different providers

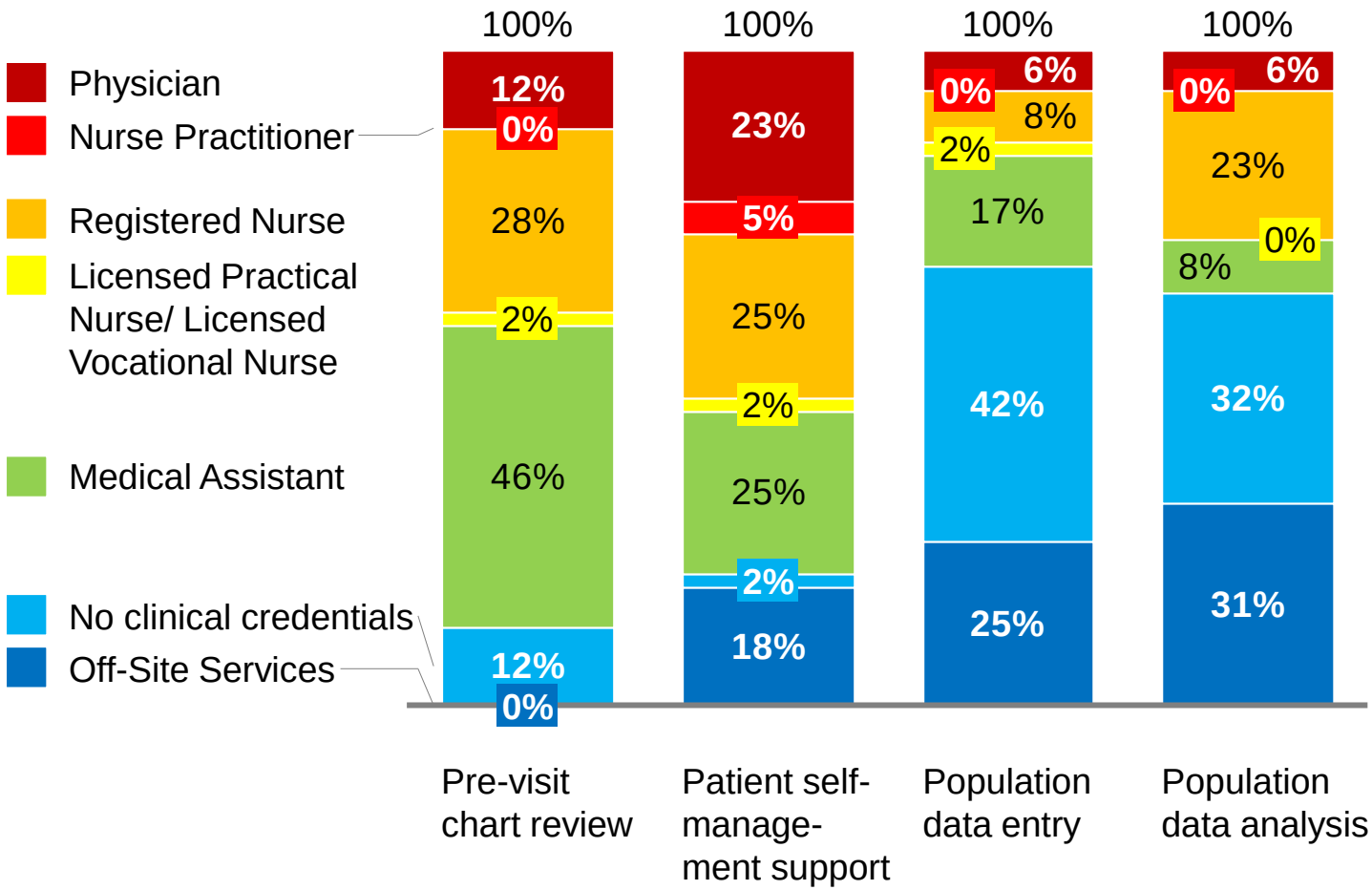


Source: Indeed.com job search results

Top of license practice

"Primary owner" of non-clinical tasks in U.S.

Percent of professionals performing each task



Source: The Advisory Board, "PCMH Staff Rising to 'Top of License'", 2012.

Comments

Questions

Survey responses prioritized six main themes

	Theme	Survey hypotheses prioritized by Workgroup
A	Health care workforce distribution	▪ Financial considerations discourage work in rural settings ▪ Health workers are underutilized in some areas
B	Primary care workforce supply	▪ There are not enough trained allied health workers ▪ New roles (e.g. care coordination) are not defined consistently across different providers ▪ Not enough NPs and/or other HCPs practice in primary care
C	Behavioral health workforce	▪ There are not enough trained behavioral health workers
D	Primary care workforce effectiveness	▪ Scope of practice regulation excessively restricts which health care workers can undertake specific activities ▪ Professionals do not practice at “top of license”
E	Skills to lead and manage	▪ Many health workers are not trained in team-based care ▪ Team management/leadership skills are not well-developed ▪ Care coordination skills are not sufficiently emphasized/developed across the health care workforce ▪ Care pathways across providers and settings are complex ▪ Many health care workers do not have the time, information, and resources to manage complex multiple chronic conditions ▪ Many health care workers do not possess the right capabilities to manage complex behavioral health issues ▪ Some health care workers lack the cultural and linguistic capabilities necessary to serve their patient population
F	Mindsets	▪ Health workers do not practice with a “population health” and team-based mindset

Comments

Questions

Source: Workgroup survey

Qualitative comments from Workgroup survey

*"I would suggest we **focus on the items we have the ability around the table to move.** Much of what's here is important but is the domain of others."*

*"I think the issue of shortage vs. maldistribution varies by profession/occupation. We **lack sufficient data** on the current allied health workforce to fully understand the issues here."*

*"We must build a strong consensus that adding to the workforce no matter how specifically well done, will change little unless a great deal of effort is put into the development of **true patient-centered consciousness and team dynamics, team cohesion**, line of sight, infrastructure support, methods and processes, and leadership."*

*"DSRIP outcomes will rest with a workforce that must deliver care in different ways . . . **behavioral health expertise** also needs to be enhanced for all."*

*"The degree of change we face calls for **big solutions**, not tinkering."*

- Desire to **prioritize the problems that are feasible for workgroup to address** given sphere of influence and timing
- Strong push to focus on the **patient-facing workforce**
- Call for more **detailed category breakdown** for various groups of professionals (e.g. allied health workers, behavioral health workers)
- Several additional points:
  - Push for **better data** and monitoring of workforce under new care model
  - Desire to focus on pipeline/education initiatives

Comments

Questions

Source: Survey n=24

Peer interview quotes: skills needs from the patient-facing workforce

Team based care

- *Teams are **not well trained to collaborate**. Need to move from **direct care delivery to care management provider***
- *HCPs may have the skills, but **lack the structure** to work in a team*
- *"Lower skilled" workers must feel **secure and safe** to express views*
- *Nurse education needs to teach **more critical thinking skills** and to **be a leader at the bedside***
- *Primary care providers and behavioral health providers must be willing to **work together to a common goal instead of in silos***

Care coor-dination

- *Care coordinators need **disease management** and **patient self-management skills…** skills not necessarily present in the hospital workforce*
- *Essential skills include **team leadership, motivational interviewing, knowledge of CBOs and caregiver support***
- *Care coordinators need to be able to **navigate the insurance system** for chronic conditions*
- *Understanding of **behavioral health and substance abuse co-morbidities***

Data and tech-nology

- *Need to know how to **leverage technology**, and how to **appreciate, interpret and apply data to make decisions***
- *All health care workers need **efficient data entry skills** and **ability to mine data and turn into useful information***
- *Need to be able to understand **outcome data, evidence based data and quality data***

Other

- *"Many current health care workers do not **understand how to work with culturally diverse individuals who are struggling simultaneously with poverty, addiction, mental health issues, homelessness and have chronic health conditions"***
- *Need to develop **cross-educational training programs** so professionals from different backgrounds learn to work together in teams*

Comments

Questions

Source: Workgroup peer interviews

Peer interview quotes: skills needs from the non-patient-facing workforce

Population health analytic capacity

- *Need analytic capability to **determine certain patient behaviors (such as frequent flyers to ED)***
- *Ability to understand **risk-adjustment factors**, **correlation** and **confounding variables** when comparing outcomes*
- *Risk stratification and value-based payment models are **entirely new to the behavioral health workforce***
- *Should be a **behind-the-scenes automatic process** and not require the front-line health provider do an analysis*

Making links to CBOs

- *Ability to **research and understand** available resources in the community; continuous ability to **update list***
- *Administrators must prioritize transferring knowledge to their staff about CBOs and **criteria for clinical appropriateness** for successful referrals*
- *Important to link with **self-management, preventative care, transportation and housing CBOs…** issue is **knowledge about the availability of these services***

Change management

- *Need to get **buy in from the staff** in order to succeed*
- ***Leadership** and **program management** skills are key…*
- *Over the next several years, **the pace of change in health care will be relentless.** Existing change management skills are **highly variable***
- ***Even the workplaces are not amenable** to team-based care and care coordination. Rooms where teams can conference are lacking…*

Other

- ***Workflow analytics is the most under-appreciated skill set that is missing in practice**. This is a discipline not yet developed in the office setting but is critical… Medical office workflows are currently so diverse and no-one is truly engaged in analyzing and resolving this really, really big problem*
- *Need to **ensure equity** in the distribution of individuals with necessary skills throughout the state and in different care settings*

Comments

Questions

Source: Workgroup peer interviews

Introduction: skills matrix exercise

Objective: In response to the Workgroup's prioritization of skills-related issues in the survey, a skills matrix has been developed as a tool to help assess areas of need. This skills matrix assumes a care model in which a physician-led team cares for a panel of patients, focusing on the chronically ill (while recognizing that care models may vary significantly across practices)

Primary care physician	▪ Responsible for health outcomes of a patient panel population ▪ Oversees the risk stratification process within the patient population and determines the patients that should receive team-based care ▪ For high-risk patients, leads the care team from a clinical perspective ▪ Determines membership of the care team and brings in expertise as required
Care co-ordinator	▪ Drafts care plans for high risk patients ▪ Oversees execution of care plan, including pre-work and follow up, and keeps care team on track from a process perspective ▪ Acts as single point of contact for the patient and their family
Other care team members[1]	▪ Fully participate in team-based care under leadership of primary care physician ▪ Provide timely and appropriate care/advice to the patient as required
Practice manage-ment	▪ Manages practice finances amidst payment model transition ▪ Manages transition (change management, risk mitigation, training and outreach) ▪ Builds links to other organizations to maximize value and patient welfare

Instructions:

- Please place stickers on the poster reflecting **your assessment of New York's workforce, on average** for that particular element
- In this way, we will have the Workgroup's opinion of major skills gaps

1 May include nurse practitioners, physician assistants, registered nurses, licensed vocational nurses

Primary care physicians: where are we today?

Functions	Initial	Developing	Best practice
Clinical knowledge	▪ Possesses general clinical knowledge of chronic disease management; uses specialists to set direction for care	▪ Supplements chronic disease management knowledge via calls with specialists to deliver more care to the patient before referring	▪ Effectively leads care of patient with chronic disease, incorporating advice from specialist physicians and other health professionals as required
Place stickers here →			
Leading team-based care	▪ Delivers care to patients within traditional doctor-patient setting	▪ Delegates some simple patient management tasks; knowledge of basic team-based care processes	▪ Confident leader of team-based care process (e.g., running multidisciplinary team meetings, managing conflict, coaching and developing colleagues)
Place stickers here →			
Using data and technology	▪ Uses technology for simple tasks, replacing previously manual processes (e.g., entering data into EHR)	▪ Uses technology to improve health care delivery (e.g. secure messaging to provide more patient touch points)	▪ Data-driven in decision making, including clinical management and resource allocation; uses EHRs and technologies to improve quality of care
Place stickers here →			
External orientation	▪ Builds networks within individual practice; professional communications mainly limited to peers	▪ Forms targeted relationships outside practice with other health care professionals, but limited in scope (e.g., primarily other physicians)	▪ Effectively builds broad professional networks to address holistic needs of patient; able to communicate with wide variety of professionals
Place stickers here →			
Under-standing and commitment	▪ Basic understanding of new care model and reasons for its introduction; views self as solely accountable for patient care	▪ Familiar with requirements of new care model; has made some efforts to review literature or consult peers about effectiveness; uses aspects of team-based care on ad hoc basis	▪ Evidence-based belief that new care model will deliver better patient outcomes; views self as part of care delivery team who are jointly accountable for patient
Place stickers here →			

Source: Interviews with Workgroup members; interviews with care delivery experts; literature review

Care coordinators: where are we today?

Functions	Initial	Developing	Best practice
Clinical knowledge Place stickers here→	▪ Basic understanding of chronic disease management	▪ Able to identify key clinical and social risk factors associated with chronic diseases	▪ Solid functional knowledge of clinical and social needs of patients with chronic conditions
Relationship building Place stickers here→	▪ Builds transactional relationships with patients and other health care professionals	▪ Uses clinical knowledge to build relationships with patients and other health care workers	▪ Builds strong trust-based relationships with patients, caretakers and other health care professionals
Managing team based care Place stickers here→	▪ Basic understanding of available internal and external resources; relies on physician to set agenda for care	▪ Sets agenda for patient care, uses physician to address roadblocks	▪ Able to effectively navigate complex internal and external system of resources; able to resolve issues independently with minimal supervision
Using data and technology Place stickers here→	▪ Uses technology to replace previously manual processes (e.g., entering data into EHR)	▪ Uses technology to improve certain tasks (e.g., deciding how to allocate time most effectively)	▪ Fully data-driven in resource and time allocation; uses technology to maximize efficiency and patient care
Developing care plans Place stickers here→	▪ Reliant on physician to draft care plans	▪ Drafts care plans with limited supervision from physician	▪ Able to draft comprehensive care plan for patient and all professionals caring for the person, for sign-off by physician
Under-standing and commitment Place stickers here→	▪ Understands importance of addressing patient's needs within the system	▪ Advocates for patient's interests in interactions with health care peers	▪ Sees self as champion for patient's interests within the health care system

Source: Interviews with Workgroup members; interviews with care delivery experts; literature review

NEW YORK STATE OF OPPORTUNITY. Department of Health

Other members of the care team (e.g., registered nurses): where are we today?

Functions	Initial	Developing	Best practice
Clinical knowledge	▪ Serves clinical needs of patients under direction of primary care practitioner	▪ Completes routine clinical tasks with minimal supervision	▪ Proactively manages standard chronic conditions within minimal supervision
Participating in team based care	▪ Contributes to patient care as directed by others	▪ Proactively engages in patient care as required to improve patient's welfare (e.g., escalates warning signs to physician)	▪ Can step up to lead patient care process where appropriate
Data and technology	▪ Correct use of basic technology tools (e.g., EHRs, secure patient messaging)	▪ Uses technology to improve care delivery and patient touchpoints	▪ Uses data to drive clinical decision-making and resource allocation
Under-standing and commitment	▪ Basic understanding of new care model and how it improves patient outcomes	▪ Personal experience of improvement in patient outcomes through higher participation	▪ Sees self as part of care team jointly accountable for patient welfare; personally committed to bringing about change

Place stickers here→

Source: Interviews with Workgroup members; interviews with care delivery experts; literature review

Practice management: where are we today?

Functions	Initial	Developing	Best practice
Financial management	▪ Familiarity with basic financial architecture of new care models	▪ Ability to estimate financial impact of value-based payment models on individual practice	▪ Able to navigate complex and shifting payment structures to optimize practice financial outcomes
Place stickers here→			
Building partnerships	▪ Focused on solving challenges within practice	▪ Builds relationships with leaders of other practices to jointly solve problems (e.g., best practice sharing, pooled after-hours care)	▪ Proposes formal partnership arrangements with organizations to improve financial and patient care outcomes (e.g., service level agreements on referrals)
Place stickers here→			
Effective change management	▪ Basic understanding of change required from a process standpoint	▪ Familiar with models of change management; comfortable in deploying one or more drivers of change	▪ Fully conversant in deploying all drivers of change simultaneously; has deep understanding of workforce needs under new care models and how to address them
Place stickers here→			
Deploying data and technology	▪ Basic understanding of technology options available (e.g., if approached by vendor)	▪ Understands what technology can offer and has some understanding of specifications required by practice	▪ Up-to-date on implementation of latest technology (e.g., patient population stratification, telehealth, EHR systems); rigorously collects data to improve practice operations
Place stickers here→			

Source: Interviews with Workgroup members; interviews with care delivery experts; literature review